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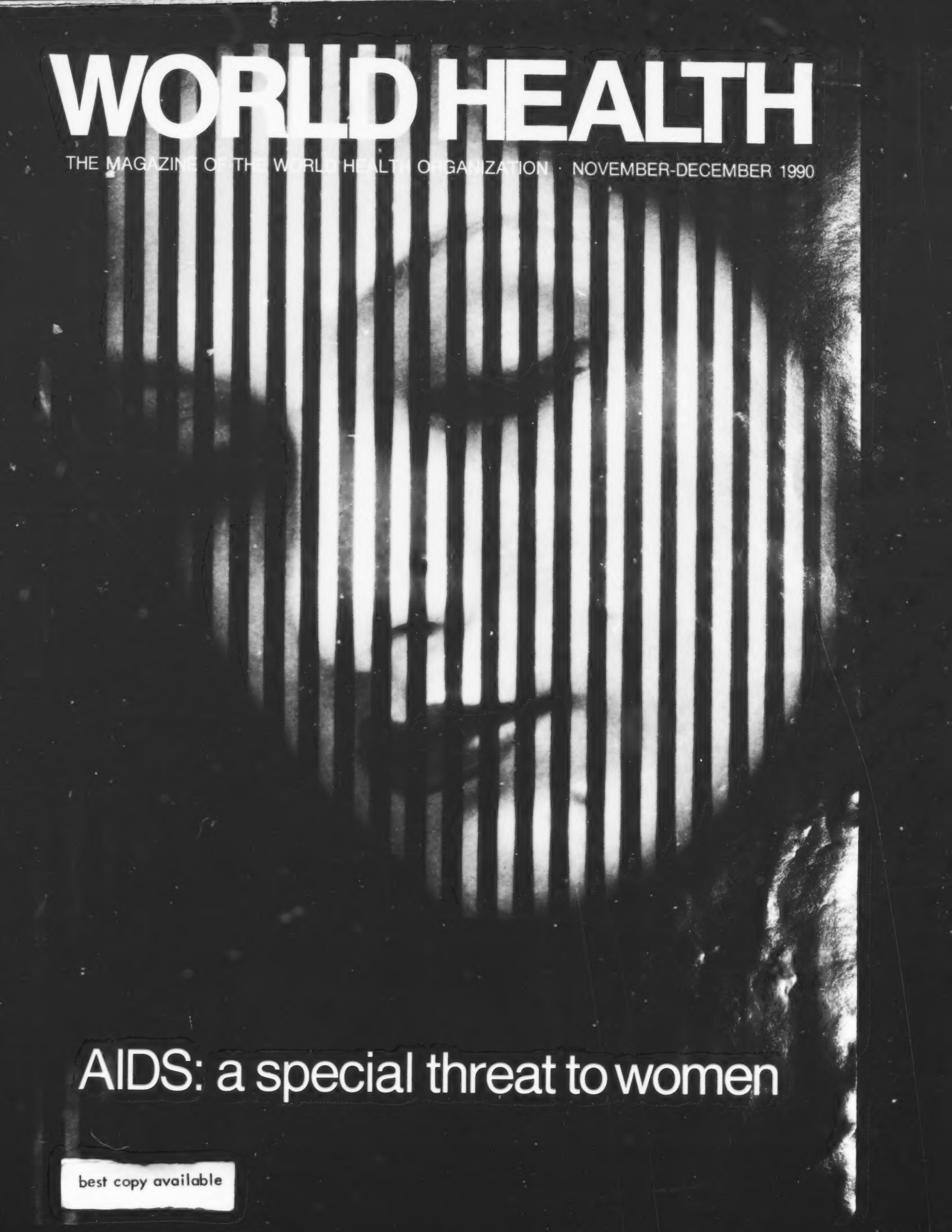

AIDS: a special threat to women

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Women and AIDS:
a challenge for humanity

by **Dr Angèle Petros-Barvazian**, Director of WHO's Division of Family Health, and **Dr Michael H. Merson**, Director of WHO's Global Programme on AIDS

Worldwide, WHO estimates that over eight million adults are now infected with the human immunodeficiency virus (HIV), and that a little over one-third – three million – are women. It is expected that 500,000 people will develop AIDS during the years 1990-1991, including about 200,000 women. By the end of 1992, a cumulative total of over 600,000 cases of AIDS will have occurred among women. By the year 2000 the annual number of AIDS cases in women will begin to equal that in men.

High rates of HIV infection in pregnant women, such as are encountered in sub-Saharan Africa and in some countries in the Caribbean, with implications for perinatal infection and elevated infant mortality, could in many countries have a devastating impact on the fabric of society. Indeed, it is estimated that, during the 1990s, AIDS will kill 1.5 to three million women of reproductive age in Central and East Africa, producing several million orphans. In industrialised countries, the present rate of HIV infection in women is still low, but it is increasing, especially in urban populations with high rates of other sexually transmitted diseases and intravenous drug use.

However, the impact of AIDS on women is not just a matter of numbers. AIDS affects women not only as individuals who are HIV-infected but also in their multiple roles in society and the family, as health care providers, educators, wives, mothers and income providers. The status of women within the family and society makes them particularly susceptible to HIV infection, a "social vulnerability" related to their generally low status. The subordinate role of women in society might vary in degree in different countries but its impact is similar everywhere. This includes the lack of equal access or opportunity for education, information and services in health, income, social rights, and so on. These undoubtedly affect their access, for example, to information on how to protect themselves from HIV infection. The stigma attached to AIDS can subject women to discrimination, social rejection and other violations of their rights. In November 1989, for the first time, an International Conference on the Implications of AIDS for Mothers and Children was convened in Paris by the French government and WHO, to discuss the policy consequences of HIV infection for these important groups of people. It was attended by ministers of health or their representatives and by scientists from all over the world. At the end of the meeting, the participants in the conference, recognising that the AIDS pandemic – closely associated with problems of drug abuse – has a particularly adverse effect on women, children and families, issued the Paris Declaration on Women, Children and AIDS, which appears in the centre pages of this issue of *World Health*.

An integrated approach

In May 1990, the 43rd World Health Assembly also adopted a resolution on women, children and AIDS – to which the Paris Declaration was attached – emphasising the importance both of an integrated approach to the health of women and of the determining role of women in development. This resolution asked the 166 Member States of WHO to ensure that programmes for the control of HIV infection and AIDS would be integrated with other programmes for women, children and families.

The low priority given to the health of women, particularly in deprived societies, has been forcefully articulated in recent years in the neglected example of maternal mortality – the tragedy of large numbers of women dying as a result of pregnancy and childbearing with no access to adequate health and family planning care. Complications of pregnancy and childbirth account for many deaths among women of reproductive age in the developing world. In certain developing countries, each time a woman becomes pregnant she runs a 200 times greater risk of dying than if she lived in a developed country. Failure to time and space and limit the number of pregnancies augments the risk of complications and death. Most maternal deaths need not happen.

The impact of HIV-related diseases among women will, if no action is taken, inevitably worsen the situation everywhere, particularly in the poorer communities. Mortality in young women from AIDS in some urban communities is overtaking mortality from cardiovascular disease and cancer.

The challenge, for all concerned, is therefore to meet the priority health needs of women, with the participation of women themselves, as well as women's organizations. This means assuring appropriate care during pregnancy and childbirth, education on prevention of sexually transmitted diseases and HIV infection, and advice on appropriate nutrition. HIV-infected women should have access to health services, including family planning, counselling and psychosocial support, so that they can personally make informed decisions about their reproductive health and childbearing. It is also important to ensure that HIV-infected women, as well as men and children, are not discriminated against and receive compassionate care.

As women will have to take upon themselves a large proportion of caring for HIV-infected persons and people with AIDS, as well as for orphaned children, and to carry much of the socio-economic consequences of the AIDS pandemic, it is imperative that they be provided with information, skills, knowledge and resources in order for their role as providers of care to be less taxing, more humane and more effective. ■

The shadow of AIDS hangs over women everywhere: girls in an Algerian classroom, a mother and child in the Soviet Union, young women in West Africa.

WHO/UNICEF/B. Wolff

Cover: Women have a right to special defences against the threat that AIDS poses to their health.
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Challenge of the nineties

by Dr James Chin

Chief of Surveillance, Forecasting and Impact Assessment with WHO's Global Programme on AIDS

AIDS was first recognized as a distinct disease entity among homosexual men in the United States in 1981. As a result, it was initially thought of as a disease which would be essentially restricted to men. Now it is becoming increasingly clear that HIV, the etiologic agent of AIDS, is a human retrovirus which in adults is primarily transmitted by sexual intercourse (vaginal or anal) or by transfusions or injections of HIV-infected blood, such as may occur in intravenous (IV) drug use.

Up to this year, the majority (about 75 per cent or more) of HIV infections throughout the world have been acquired via sexual intercourse, *mostly heterosexual*. Epidemiological and virological studies from throughout the world have clearly documented the transmission of HIV via vaginal intercourse from an infected male to a female and from an infected female to a male. The risk of HIV transmission from a single episode of vaginal intercourse is not known, but has been estimated to be very low (1 per 500 or 0.2 per cent), compared to other sexually transmitted disease agents such as gonorrhoea (about 30 per cent). Nevertheless, a single heterosexual encounter is, in some instances, sufficient for transmission of HIV infection. There is increasing evidence too that the presence of other sexually transmitted diseases (STDs), especially those associated with genital lesions such as syphilis and chancroid, may increase the risk of a single exposure by 10 to 20 times.

Another key factor involved in heterosexual transmission of HIV is the likelihood of exposure to an infected partner. In areas where HIV infections are low to absent, there would be virtually no risk of acquiring an HIV infection via sexual intercourse (or by any other type of exposure). But, the prevalence of these infections is steadily increasing in most areas of the world and so is the risk of exposure to an infected sexual partner. Where HIV infections are known to be prevalent, selection of sexual partners who are not at increased risk is of paramount importance for avoiding acquiring an HIV infection. There is obviously an increased risk with increased numbers of different sexual partners.

There are also gradients of risk of HIV transmission associated with different types of sexual contact. The highest risk is from being the receptive sexual partner, whether this is heterosexual or homosexual intercourse. So women, who are the receptive partners in sexual intercourse, are thought to run a higher risk of acquiring an infection from the infected male partner than men do from an infected female partner.

The natural history of HIV infection has essentially been studied in homosexual men and persons with haemophilia (also all males), and is known to cause progressive damage to the body's immune system. When sufficient damage to the immune system occurs, the infected person is then susceptible to a vast array of opportunistic infections and rare cancers, which are the clinical indicators of the underlying immune deficiency due to HIV. The average period from infection to the late clinical stage (that is, AIDS) is about ten years.

Whether the natural history of HIV infection in women differs to any significant degree from that outlined for men is not known, and the detailed studies needed to answer this question are very difficult to plan and put into effect. In the absence of such specific data, it is reasonable to assume that no major differences exist between men and women. Although some early reports suggested that pregnancy might accelerate the clinical progression of HIV infection, subsequent studies suggest that pregnancy *per se* is not a major factor.

WHO has described several broad yet distinct epidemiological patterns of HIV infections and AIDS cases. The factors responsible for these patterns include the probable date of HIV entry and/or the period when HIV began to spread extensively in the population; and the relative frequency of the three modes of HIV transmission – sexual, parenteral (by injection) and perinatal.

In *Pattern I*, the primary population groups affected have been homosexual men and IV-drug users; the extensive spread of HIV began between the late 1970s and the early 1980s. Heterosexual spread of HIV also occurs and has been increasing, but still accounts for only a minority of new infections. This is the pattern currently seen in the countries of North America, Western Europe, and Oceania.

In *Pattern II*, HIV/AIDS is found predominantly among sexually active heterosexuals; extensive spread of HIV probably began in the mid-to-late 1970s. This is the current pattern in sub-Saharan Africa and some parts of the Caribbean.

Areas currently classified as *Pattern III* include Asia, most Pacific countries (excluding Australia and New Zealand), Eastern Europe, North Africa, and the Middle East. In these areas, HIV was introduced in the early-to-mid 1980s. Although indigenous spread of HIV has been documented in most of these countries, the prevalence of both AIDS cases and HIV infections was low at the end of the 1980s, and no clearly

WHO/H. Anenden

Women researchers in Kenya are helping in the work of tracking down the HIV virus and seeking means to combat it.

predominant mode of HIV transmission has been documented in most countries. This situation has changed markedly in some South-East Asian countries such as Thailand and India, and as of mid-1990 there are an estimated 200,000 HIV-infected women in Asia.

Vulnerable groups

In many Pattern I countries, HIV infection has, during the late 1980s, been increasing in the most socially and economically vulnerable segments of society. This is particularly true in the United States, where blacks and hispanics in the inner city areas have become increasingly and disproportionately affected, mainly due to the large numbers of intravenous drug users (IVDUs) in these populations. So we may expect an increase in the number of HIV-infected women as a result of sharing infected drug injection equipment and as a result of heterosexual transmission from HIV-infected male IVDUs to their sexual partners.

Many Latin American countries (Central and South America) were initially classified as belonging to Pattern I. But by the mid-to-late 1980s, sexual transmission among heterosexuals had increased to such an extent that Latin America has been reclassified as a separate pattern – Pattern I/II.

In Pattern II areas, transmission continues to remain predominantly heterosexual. The prevalence of HIV infection continues to rise in urban areas and, increasingly, its spread to rural areas (where the majority of the population lives) is being noted.

In a few Pattern III countries previously only slightly affected during most of the 1980s, extensive spread of HIV infection has been noted among IVDUs and prostitutes during the late 1980s. Thailand has documented extensive spread of HIV infection in Bangkok among IVDUs (mostly, but not all, males) since early 1988, and HIV prevalence estimates have risen from about one per cent in late 1987 to about 50 per cent up to early 1990. In addition, focal increases of HIV prevalence ranging from ten per cent up to 70 per cent have been found during the last couple of years among female prostitutes in several cities in Thailand and India.

WHO estimates that to date a total of eight to ten million adults have been

WHO/Hernandez Chiu

Taking a blood sample in a Mexican AIDS clinic. Latin America is classified as a Pattern I/II region.

infected with HIV. Based on the lower range of this estimate and on reported male-to-female ratios of AIDS cases or of HIV serological data, the numbers of HIV-infected females age 15 to 49 years were estimated for all global regions. Of the global total of eight million infections, over a third or three million are women, most of whom are of childbearing age. The majority of infected women (more than 2.5 million) are in sub-Saharan Africa. HIV prevalence ranges from a high of about one infection for every 40 women to a low of less than one infection for every 20,000 women in some Pattern III areas such as Eastern Europe.

Up to the present in most of the industrialised countries, the primary population groups affected by the HIV/AIDS pandemic continue to be homosexual or bisexual men and IV drug users (men and women). During the 1990s, transmission of HIV in homosexual and IVDU populations can be expected to continue but, in general, not at the very high rates documented during the 1980s. Heterosexual transmission of HIV is, up to 1990, the predominant mode of HIV transmission worldwide, mainly because of the large numbers of HIV-infected persons in sub-Saharan African countries.

Heterosexual transmission

Over the next several decades, heterosexual transmission will increasingly become the predominant mode of HIV transmission in most industrialised countries. However, the rate of increase of heterosexually transmitted HIV infections in these countries will be low compared to the very large increases observed among homosexual men and IVDUs during the first half of the 1980s. Nevertheless, since the pool of heterosexuals who may have multiple sexual partners is very large compared to homosexual men and IVDUs, the number of heterosexually acquired HIV infections expected during the 1990s will be greater than the total number of HIV infections acquired through all routes of transmission during the 1980s. Worldwide, by the year 2000 the annual number of AIDS cases in women will begin to equal the number in men. It follows that HIV/AIDS prevention and control programmes will need to develop appropriate education and other public health measures to respond specifically to the growing problem of this disease in women. ■

The special threat to women

by Dr Rosmarie Erben

Health Promotion focal point, WHO's Global Programme on AIDS

Men can protect themselves against the sexual transmission of HIV. Women find it more problematic. This is the difficult issue that challenges health promotion.

The condom is seen at present as the only effective preventive measure against sexual transmission of HIV. Yet, for many women – whatever the cultural context – to suggest to their husband or partner that he use a condom is seen as evidence of the woman's infidelity or is felt by the man as defiance or insolence. This results at best in painful discussions and a breach in the relationship, or at worst in the woman being beaten and abandoned. In cultures where the married woman is traditionally expected to bear many children, insisting on safer sex or refusing to engage in sexual relations is impossible.

These "facts of life" become even more dramatic when we look at the statistics. Some 200,000 women are expected to become ill with AIDS in 1990-1991 – more than the total of all those who have developed AIDS since 1980; a seroprevalence of 20 per cent in pregnant women causes infant mortality rates to increase by 36 per cent; about three million women are currently HIV-infected; and finally, over 100 million cases of sexually transmitted diseases are reported each year, pointing to the enormous potential for sexual transmission of HIV.

With the AIDS pandemic, as with many other health problems, women have often been viewed as "reservoirs of infection," posing a threat to men, and also to their babies, since vertical transmission has been recognised. This concept has denied the reality that women get infected either through sexual contact with men who, too often, refuse to use condoms, or through unsterile injection equipment used either in the medical environment or to inject psycho-active drugs.

The way we perceive ourselves and others, the way we express ourselves with our bodies, the way we use our bodies and protect ourselves or not from health hazards are all developed in relation to the culture in which we live, within an overall framework of individual and collective ways of living. The choices we are able to make vary from culture to culture, and are dependent on the living and working conditions common to our society.

Negative influences

The ability of women either to protect themselves from infection or, in case they are infected, protect others, is negatively influenced by several factors: *psychosocial*, *cultural*, and *legal barriers* to women's decision-making or independent action; the relative *lack of economic alternatives* for women, and their consequent dependence on men for support; women's *role as primary caretakers* of children, husbands or partners and parents; women's generally *lower literacy*, *limited mobility*, and *limited access to information*; and last but not least, cultural and moral *attitudes towards sexuality*. The vulnerable position of most women when it comes to sexual practices has to be recognised. Confronted by this situation, what can health promotion hope to achieve?

With the advent of AIDS, health promotion has taken on a sense of urgency. People have suddenly realised that behaviour – individual and collective – can dictate a sentence of death. In recent years, health promotion has helped gay men in the industrialised world to effect major changes in individual and group sexual practices. But only as we move into the 1990s has the world started to recognise the special threat that AIDS poses to women.

Health promotion uses five key areas as its framework for intervention: they refer to public policy, supportive environments, community action, individual skills and health services. In the *public domain* it goes beyond health care. It aims to combine complementary approaches, including legislation, fiscal measures and organizational changes leading to health and social policy that in turn foster greater equity.

Present approaches vary widely. In one country, for example, HIV-infected

WHO/J. Hernandez-Claire

"Only as we move into the 1990s has the world started to recognise the special threat that AIDS poses to women."

professional blood donors (virtually all men) are not isolated or punished. Prostitutes who test positive, on the other hand, are quarantined and held in prison long after their legally imposed sentences. Thirteen states in the USA have passed laws making compulsory the testing of individuals convicted of prostitution (85 per cent of those convicted are women). Proposals to test men have not been enacted into law.

Not really powerless

The need for *supportive environments* arises because fear and prejudice are the primary attitudes towards women who are HIV-infected or have AIDS. They may be denied medical assistance, rejected by their family and friends, and forced to leave their jobs. "If women can't get support from their families, they can get it from traditional organizations and women's groups. Women are not really powerless. It is a question of identifying our strength," says an organizer of the Zimbabwe Women's AIDS Support Network. The Network gives women the confidence to fight AIDS and suggests ways of doing so in a society where women have little control over the sexual behaviour of their menfolk.

The need to change social attitudes towards women who are HIV-infected or have AIDS, and to promote a more positive environment, is high on the list of health promotion priorities. Indeed one main objective is to establish closer communication between those affected by the virus and that part of society that defines itself as healthy.

An important aspect of supportive environments is "to make the healthier choice the easier choice" and facilitate non-risk behaviour. In the case of AIDS, this means easy access to condoms. Programmes of free distribution exist in some countries and are supported by WHO.

Examples of *community action*, especially through effective self-help and support groups that women have set up, can be found in many countries. Such groups in India, the Philippines, the Republic of Korea and Thailand have worked for better information, education and treatment of women with HIV infection. They have campaigned to have HIV-infected women released from detention and lobbied for the free distribution of condoms to tourists. They have fought for the rights of people with AIDS and their families. "EMPOWER" is a support group run by and for women working as bar hostesses in Bangkok.

WHO/J. Hernandez-Claire

Women's community action groups can play a crucial role in pressuring governments to change laws or reorient budgets to ensure that funds are allocated for AIDS prevention and care. Increasing the involvement of non-governmental organizations, particularly at the community level, is a must.

What about the *individual*? The process of "enabling people to increase control over their health" is at the heart of health promotion. Hence the focus on providing information and enhancing life-skills. Most studies carried out in various cultural and economic contexts reflect misconceptions and considerable confusion about HIV transmission and AIDS. So it is important to study the knowledge, attitudes, beliefs and behaviour of women and link the results to information and education activities. How to reach women in certain cultural settings and how to communicate with them are also major questions for health promotion research.

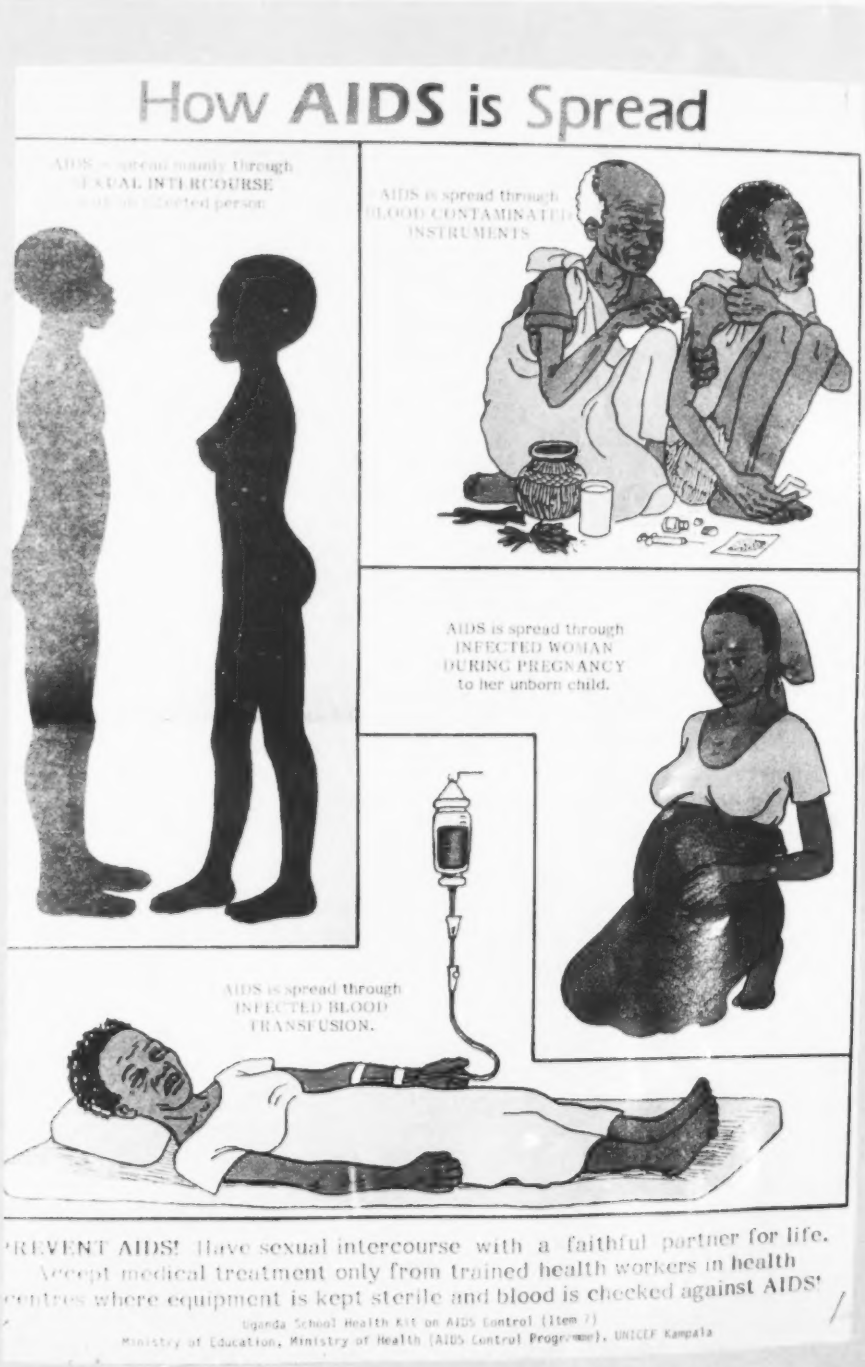
"Safer sex" workshops are an important component of health promotion, both by encouraging women to think creatively about sexuality and by providing practical information. They can be run by trained female health educators, but members of peer groups can also be trained and usually prove extremely effective. In developing personal skills, it is vital to use the language of the women themselves and to rely on interactive processes.

As for the *health services*, the prevention and control of HIV infection must be closely tied with existing services for women, mothers and children. All services providing maternal and child health care, family planning and treatment of sexually transmitted diseases must ensure that HIV/AIDS activities are integrated in their own activities. In addition, women must have access to safe blood supplies and safe medical injections. In the developing world, most blood transfusions are given to women and young children in connection with childbirth and its complications.

On the broader level, health services need to be more sensitive to cultural needs and client expectations. Too often, health care is given from the perspective of the health care providers irrespective of how appropriate this may be for the patient. What women desperately need, very often, is more attention and support.

Finally, health promotion cannot be achieved by the health sector alone. It demands coordinated action by governmental and voluntary organizations, by local authorities, industries and the media. It offers opportunities for new, broad-based health-oriented action. In the case of women and AIDS, it is directed against the stigmatisation and social disadvantage experienced by those affected by the disease. It seeks to enable women to say "No" to sex risk behaviour, and this means giving them knowledge, social support and economic independence. In short, health promotion calls for concrete and efficient action, tolerance, equity and solidarity. ■

WHO/J. Hernandez-Claire


How AIDS is Spread
AIDS is spread through BLOOD CONTAMINATED INSTRUMENTS
AIDS is spread through INFECTED WOMAN DURING PREGNANCY to her unborn child.
AIDS is spread through INFECTED BLOOD TRANSFUSION.
PREVENT AIDS! Have sexual intercourse with a faithful partner for life.
Accept medical treatment only from trained health workers in health centres where equipment is kept sterile and blood is checked against AIDS!
Uganda School Health Kit on AIDS Control (Item 7)
Ministry of Education, Ministry of Health (AIDS Control Programme), UNICEF Kampala

Left: ***The concept of women as "reservoirs of infection" denies the reality that women get infected through sexual contact with men, as well as by drug abuse.*** **Right:** ***A poster from Uganda explains the transmission of HIV infection.***

Two voices

by Mrs Elizabeth Reid

This is a plea for voices, a plea for stories. My husband's voice is stilled now and you can only hear his thoughts through me. By now, hundreds of thousands more voices have been stilled. Many of their words may live on with their lovers and carers. These and the voices of the living need to be shared so that we can build up the tapestry called Living with HIV.

We need to weave two panels. One blends the voices of those living with the knowledge of their infection with the voices of those caring for them, who see and also understand what it is like to live with infection. The other panel must be that of the carers as carers.

It is now over four years since Bill died. He died on the last day of an Australian winter. He could not have said it when he died, since he had totally withdrawn into the silence of dementia, and possibly could not have thought it, but he would have wanted it like that, wanted to leave our son John-William and myself the spring – a time of healing and of the creation of a new life.

For me, a part of that new life is the attempt to understand that past, to reflect upon those years, to become more articulate about what was done, often intuitively, and to share some of the happiness and hope that we experienced. So here are our two voices, halting as yet, talking about two difficult subjects: living with HIV and living with dying.

A growth in the minor intestine caused Bill to bleed internally early in 1983. In the months that followed, he was given massive amounts of blood clotting products to stem the bleeding. He was diagnosed as infected with HIV in April 1985, 16 months before his death. Of those 16 months, three long months were spent trying to work out how to live with that knowledge.

Before that, we had for over two years lived our lives with an underlying and hidden fear. For although the world in those years, 1983 and 1984, kept telling us that the chances of infection through a blood transfusion were one in a million and so not much higher for blood products, we nevertheless, and rightly, feared it was otherwise. So we lived with infection, or the fear of infection, for three and a half years and with the final long-drawn-out dying for over six months. They were years of great happiness and closeness for both of us, right through the dying, through dementia to death.

A hidden hope

Living with the fear of the possibility of infection was for us very different from living with the knowledge. Hidden along with the fear was the hope that it would not be. Bill's hope was shattered, as often it has been for too many others, by two atomic sentences: "Your result is positive. Sorry." No counselling. No help. No shoulder. No friends that he dared to turn to. He cried alone. I was not there.

My hope was shattered by just one atomic sentence: "My result was positive." We were separated by half the world and by a crackly echoing telephone line. He had just been tested in Zaire where he was doing a couple of months' work. I was in Australia. He was speaking obliquely from the public lounge of the guest house where he was staying, trying desperately to ensure that no-one else could understand the import of his words. Having lived with haemophilia all his life, he understood the need for very careful consideration before disclosure. I was so profoundly alone in dealing with the knowledge of his infection that, for the few weeks before his return, I spoke without thought of the consequences.

It was a difficult struggle to learn to live with this knowledge, for both of us. Bill returned to Australia in early May, and there followed a period of distress and turmoil, a period of awful separateness in a relationship that was very close.

The losses were immediate. In retrospect, I believe that Bill may have spent those first months grieving, grieving for the might have been, for the dreams. We had met only a few years before. Our professional lives and our personal lives interwove with a promise of great fulfillment. He became different from his usual self, refusing to buy new shoes for they would be wasted, seeking to experience all as if it were his last chance.

For me the overwhelming loss was not being able to have more children. We had one child, John-William, but as a mother in my middle years I felt that two at least might ease my way. We had lived in fear of Bill being infected since John-William was seven months old, and so the grieving for the children that might have been had started then but now it had an absolute finality about it. There was no more hidden hope.

The feeling of hopelessness was overwhelming. Bill was infected and there was no way to do anything about that. We were left with a sense of deep bewilderment, of absolute powerlessness in the face of this knowledge. This powerlessness sapped our vitality, kept us apart. We became crabby with one another.

We were afraid. The fear was not so much of the death but of the dying. We had seen the ravages of the disease in the United States and in Africa. We had seen young wasted bodies refusing to die easily. We deeply feared that Bill's mind would be affected, that he would become demented. The fear of dementia was for us more terrible than the fear of death. Death and dementia elicit no other emotion in our culture.

No support

We were alone. We had closed ranks, drawing a now inflexible line around the knowledge. My family knew, and one or two others whom I had told in the first shock. John-William, Bill and I went to the local clinic for further testing. We were asked in detail, for research purposes, about our sexual and drug-taking habits but were given no help, no support, no counselling. We were later to find out that there were other known HIV-infected persons in Canberra, one of them an old school friend of mine. But someone made the decision not to put us in touch; someone had the audacity to decide that our assumed differences in sexual orientation were greater than that shattering thing we had in common.

Perhaps worst of all, we refused to look inwards. We were not ragers and so did not go out raging. The fullness of our relationship meant that there was no impulse towards sexual binges, safe or otherwise. But we were groping blindly around in our own and individual ways, refusing to confront the inner

turmoil. This was our form of denial. It is the opposite of learning to live with the knowledge of infection. It is the refusal to start the journey of becoming more fully who you are, of finding a sense of peace and strength.

For three months we journeyed separately, alone. The difficulty of the journey was compounded by the fact that work was difficult to find in Australia. We had worked happily and well in Central Africa since 1981, but had recently decided to return to Australia to be near my daughter, Kathryn. Finally Bill made a number of decisions: he wanted to live; he wanted us to stay together; and he wanted work that was challenging and worthwhile. At much the same time, I too decided that I wanted us to stay together, but I wanted us to settle down in Australia and establish support networks that would help us through the coming years.

Eventually I realised that the decision had to be that we would return to work in Zaire, where work was waiting for Bill. This would give him back his *joie de vivre*, his sense of living a life worth living, of living. We had stumbled through debilitating denial, helplessness, distress, turmoil, powerlessness. We stumbled into living. Once there, things fell beautifully into place.

How did we make that transition from diagnosis to living? Much of it had to do with the sort of person Bill was. He had a strong desire to continue living. He believed that life was worth living, that we had much more happiness to find and that we had worthwhile work to do. He realised that not taking his life into his own hands was leading to a death wish, a sense of hopelessness and helplessness.

Bill had fought all his lifetime not to have his haemophilia considered by himself or others as a handicap. He knew his physical limits, continually pushed them as far back as possible, but had learnt to listen to his body. He was skilled at drawing the boundaries between the possible, and the desired but not possible. His boundaries were broader than most people's, with or without haemophilia – including, for example, travelling by bush taxi from Dakar in Senegal south to central Africa and then up to Addis Ababa in Ethiopia, carrying his blood clotting factor in his briefcase. But he knew how to identify these boundaries and that he had to live with them.

Bill loved living. He had a love of people, of listening, of learning. In short, he was gregarious. The sheer love of interacting with others helped draw him, and me with him, back into living.

The living that we found was simple enough: we did those things that we would have been doing anyway. We led full, happy lives. The reality of his infection had been acknowledged but placed in its proper perspective. And life continued.

WHO/L. Taylor

Haemophiliacs who needed regular blood transfusions in the early 1980s lived with infection, or the fear of infection, from the time that the AIDS virus was identified.

So little together

As a carer, I had failed my first task. Our journeys to living were journeys made alone, not together. I had not been able to help him through from diagnosis to living. Throughout the time I knew Bill, it was the only period that we shared so little, that we were so little together in spirit and intellect. However, we did somehow reach the living together and then my role as carer changed back to that of lover, of opponent in the word-game of Scrabble, of dinner companion, of co-worker.

Sadly, our period of living with HIV was short, just six months, before the dying began. But thank heavens we had made that transition to living, for we were to learn that the living we had learnt can continue through the dying. We had learnt the skill of living whatever life was possible. For us, this was to be especially important, for the virus soon began to impair Bill's mind.

This was what we had most feared. Too little is known even today about the effect of the virus on the mind. Then much less was known. Most people around us responded by ignoring or denying it. But one of the striking things about HIV encephalopathy, sometimes crudely called AIDS dementia, is that, unlike other forms of dementia, the person seems to remain, at least until it is quite advanced, conscious of the changes in himself or herself. So Bill and I charted its progress together: his temporal disorientation, his shortening concentration span, his memory lapses, his decreasing ability to solve problems. Together we began to find ways to help him around them.

Bill continued to live and to respond in whatever ways were possible. Now we took pleasure in playing just a few opening moves of Scrabble. Then later as he withdrew more and speech ceased, there was still the turning of the head at my footsteps, the meeting of the eyes, the warmth of his hand. Our relationship continued. Some integral part of the person continues to respond. The essential person remains through everything, untouched by the dementia. But this person becomes very difficult to reach. Care-givers need skills to cope with this dementia. Fear of the unknown can be overpowering.

Living with dying was not always easy. The dying of this disease can be so painfully slow. There were times of deep depression, for each of us. Fatalism and despair lurked in the

shadows, at least for me, fed by uncertainties about prognosis and treatment. I faltered from time to time. But Bill's desire to live whatever life was possible was strong. His body was still young, unprepared to die.

During the dying, the role of the carer changes. He or she not only remains a partner of the living but now becomes the midwife for the dying. This role is almost impossible to take on unless the carer also has learnt to live with HIV. The carer becomes acutely aware that he or she is not the dying but only the observer of the dying.

The carer therefore lives in two worlds: one of the dying, the other of the present and future living, the pain for the now and the pain for the future. The distress is immense but for most of the time cannot be expressed, since it gets in the way of the living.

Afterwards there is virtually no choice but to continue living. But the disease itself and its social stigma mark the survivors.

Bill lives on in our discourse, in our memories. His special human and moral qualities continue to influence our lives. He is a loved presence and this is the way it should be. But when John-William continues our conversations with others, strangers or new acquaintances, he cannot understand when people react with such hostility or recoil when he says, as he must be able to, that his Dad died of AIDS.

Public discourse links AIDS to sexuality. The vocabulary is too often that of deviance: promiscuity, perversion, revulsion. For us, AIDS is also linked to loss, grieving, absence. The children who survive may be marked by the discourse about, and the reality of, AIDS; their psychological, emotional and sexual development may be adversely affected.

Sexual identity

The survivors who were partners, spouses, lovers, carers may find their own sexual identity, and their ability to express it is deeply affected. This will be difficult for them to work through as long as the world remains riddled with denial, fear, ignorance and repugnance, for as long as it lacks a perception of common risk of infection.

If these journeys were not unique, then a number of important threads might be able to be drawn from them. Diagnosis of HIV need not be a diagnosis of a terminal illness. Rather it is a diagnosis of a particular kind of life.

"Me, I prefer to know" declares this young woman, advocating free and anonymous AIDS testing.

Learning to live with HIV is best done when one is asymptomatic. The earlier a person can make the transition from diagnosis to living, the better the quality of the living and, maybe, the longer the life. The activities which make this transition possible are those which regain or maintain control over one's life. They will vary from person to person. They might include taking control over one's health and treatment, identifying the things which make life worth living, giving it structure, purpose, direction or meaning.

We need more research that gives hope, studies of the living well, those infected whose lives are full and happy, the long-term survivors. People, in short, who have made the transition from diagnosis to living with HIV. We need to see these people in the medical literature as well as hear their own voices. Such research will be important in correcting the distorted, fatalistic picture that emerges from the press, public health officials and scientific journals, and which so harms those affected.

Carers, families, friends, counsellors, support groups, community organizations will need to have the skills required to help people through the process from diagnosis to living with infection. More needs to be known about how this transition can be brought about. We need to know much more about how the mind is affected by the virus and to be able to devise creative ways of caring for those so affected. In particular, we need to learn different ways of communicating with them, for example, by touch, by massage, by music, by eye contact.

The stigma surrounding this disease as well as the stigma marking many of those who are affected – prostitutes, homosexuals, drug users – needs to be challenged. This epidemic is a tragedy, and a challenge, to the whole human community. The community of those affected includes survivors as well as the infected and their loved ones and carers. They will all have special needs arising from the nature of the disease and its social, cultural and psychological setting.

At the heart of this epidemic, either there can be violence and fragmentation or there can be stillness. In the hearts of those affected, it is the same. Knowing how to live with HIV can bring a stillness to the centre of the living and the dying, a stillness that creates life. ■

Mrs Elizabeth Reid, who is Programme Director of the Division for Women in Development, UN Development Programme, New York, based this article on a speech given to the Living Well Conference, Melbourne, Australia in 1988.

Mother to child

by Dr David L. Heymann

Acting Chief, Office of Research, WHO's Global Programme on AIDS

For a child to die of AIDS is tragic; even more tragic is for the mother to discover that the baby got the infection from her and that she herself may soon die, leaving the other children which she has borne without a mother. These are among the legacies of AIDS – a pregnant woman infected with the human immunodeficiency virus (HIV), the cause of AIDS, who passes it unknowingly to her unborn child. If the father is infected with HIV as well, those other children will one day become complete orphans.

AIDS occurs all over the world: WHO now estimates that over three million women are already infected with HIV, and infected pregnant women are thought to have a 15 to 45 per cent chance of passing the virus to their children before, during or shortly after birth. Most of these women do not know they are infected. Adults can be infected for as many as ten or 15 years without developing any signs or symptoms of AIDS. Because HIV infection does not reduce fertility, infected women may have many children while they are infected with the AIDS virus; scientists do not know why some of these children will be infected, while most of them will not.

Ten million orphans

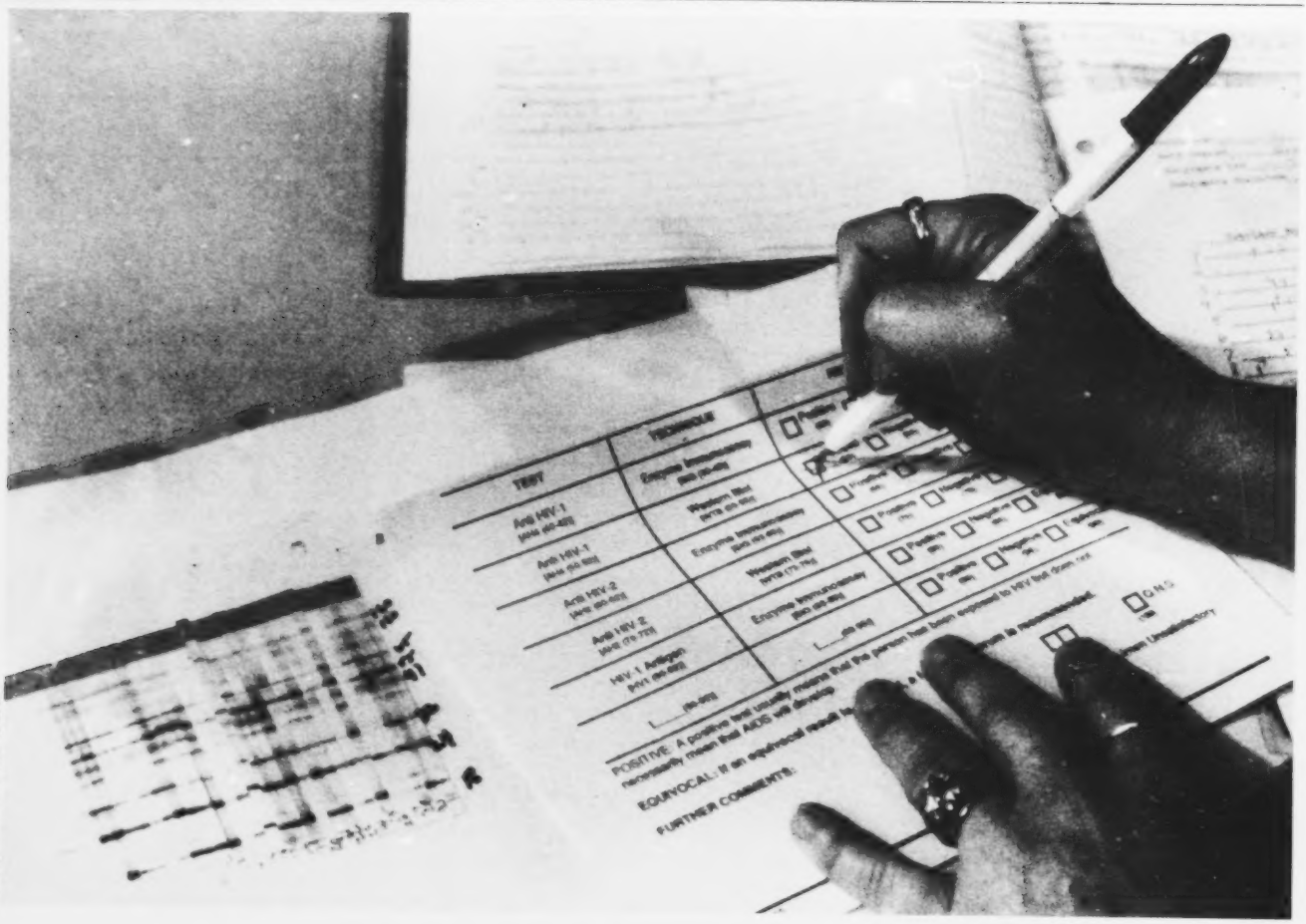
WHO estimates that over half a million children have already been infected with the AIDS virus, and that by 1992 this number will have doubled. During this same period, it is estimated that over three million uninfected children will have been born to mothers infected with HIV and that, by the year 2000, there will be over ten million uninfected orphans whose parents have died of AIDS.

In many countries where today the threat from AIDS is greatest, it was unheard of for children to have no family to care for them. If a child's mother and father died, other family members usually assumed responsibility for taking care of the child until adulthood. Now, however, in some of these countries, extended families are already overwhelmed by other children whose mothers and fathers have died of AIDS, or the remaining adults are themselves sick with AIDS, and unable to care for them. Some family members do not accept even uninfected orphans because of the false belief that they will bring them bad luck or even infect them with the AIDS virus. Orphans have therefore become a tragic legacy of AIDS in many countries around the world which do not yet have the necessary social structures to cope with children who have no families.

At present the course of infection in children with the AIDS virus is not

WHO/E. Mandelmann

A healthy newborn baby protests against the world's injustices. In fact, the world is witnessing a rapid advance of AIDS among children.


TEST
FEMALE
Anti HIV-1
Anti HIV-1
Anti HIV-2
Anti HIV-2
HIV-1 Antigen
POSITIVE: A positive test usually means that the person has been exposed to HIV but does not necessarily mean that AIDS will develop.
EQUIVOCAL: If an equivocal result is
FURTHER COMMENTS:

WHO/CDC Atlanta USA

The "Western blot" technique is a way of detecting the antibodies transmitted from the mother to her child. **Right:** ***Breast-feeding, in spite of the small risk of transmission of HIV, should continue to be actively promoted.***

completely understood. An unknown percentage of children who are born with HIV infection develop signs and symptoms of AIDS during the first year of life and die before their second birthday. Others become ill later in infancy and early childhood and may survive to the age of four or five. Still others remain asymptomatic well into school age.

Many childhood diseases, such as measles and diarrhoeal diseases, are more severe in children who are infected with HIV. Therefore, WHO and UNICEF recommend that all children who are born to HIV-infected mothers, whether or not they themselves are infected, be immunized against diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, measles and tuberculosis. One exception is that children who show signs of advanced HIV-infection should not be vaccinated with BCG, the vaccine that prevents tuberculosis, because this vaccine can cause serious side-effects in these children. HIV-infected children who have signs of advanced infection should, however, like all children, be immunized with all the other usual vaccines of childhood.

In the rare situation when a woman has been infected with the AIDS virus through transfusion of infected blood shortly after delivery, it has been shown that the AIDS virus could be transmitted through breast-feeding. Such instances are very uncommon and the risk of becoming infected by breast-feeding is low. In fact, the risk is much less than the risk of other infections, including diarrhoeal diseases, which can occur if the baby is not breast-fed. WHO therefore recommends that breast-feeding by the mother should continue to be actively promoted for all infants whether or not their mothers are infected with the AIDS virus.

One means of reducing the number of infants who are infected with the AIDS virus before or at birth is for women who are considering pregnancy, and their sex partners, to undergo voluntary, confidential testing for HIV antibodies. If one or both members of the couple are shown to be infected with HIV, they can then decide whether or not to continue with attempts to have a child, taking into account the risk of transmitting the infection to the infant during pregnancy. This decision may be extremely difficult, since having a child is very important for many couples. Furthermore, if the man is HIV-infected and the woman is not, she may become infected as well while attempting to become pregnant.

Questions and answers

Research on mother to child transmission is focusing on the question of whether there is a biological reason that the AIDS virus is transmitted to infants in some pregnancies only. Answers to this and other related questions will perhaps provide a basis for specific treatment, or eventually a vaccine, that will help to prevent transmission of the AIDS virus from women to their infants.

Until more about mother to child transmission of HIV is understood, women and their children who will die with AIDS and children who are uninfected and left as orphans remain tragedies of the AIDS epidemic that demand both compassion and responsible decisions about sex and reproduction. ■

WHO copyrighted photo by Paul L. Pottinger

Strip cartoons to warn and inform

Nobody doubts the value of strip cartoons as a means of conveying health messages to young people. So why not use them in an effort to prevent one of the greatest threats to young people's health – AIDS? For the Swiss artist Derib, already well-known in Switzerland among connoisseurs of strip cartoons, the question is no sooner asked than answered.

Setting aside his usual work for a time, he decided to concentrate on creating an 88-page strip cartoon on AIDS prevention. Some 700,000 copies will be handed out free of charge next spring to all Swiss youngsters aged 14 to 20. If the campaign succeeds, the distribution may be extended to other countries of Europe and the rest of the world.

The heroine of the booklet is called Jo, and her story is intended to alert young people to the dangers of AIDS that menace all of them if they are not fully informed.

To get the best possible impact, he has formed a "reading group" of 200 people who have studied the scenario and who ensure that the storyline faithfully reflects real life. "The story concerns two young people, Jo and Laurent," the artist explains. "They are in love but have to confront the horror of this disease."

To finance this ambitious project, a group was formed recently called Foundation for Life. Sponsored by personalities from the arts, sport, science and politics, the foundation has the long-term aim of training high school children who in turn can pass on the information to other youngsters, to families and to schools and other educational institutions. Any profits from subsequent sales of the strip cartoon will go to the Foundation.

As Derib says: "We have to warn and inform the youth of today about the threat of AIDS. In addition – and this is vital – we have to offer them a little hope; they have a right to such hope – even if it's hard to find a silver lining." ■

Paris Declaration

on women, children and the Acquired Immunodeficiency Syndrome (AIDS)

United Nations stamp produced for the worldwide struggle against AIDS.

The International Conference on the Implications of AIDS for Mothers and Children was held in Paris from 27 to 30 November 1989, to hear scientific presentations and to discuss the policy implications of human immunodeficiency virus (HIV) infection for these important population groups. Based on the discussions and findings from the Conference, the assembled Ministers of Health and their representatives declare:

Considering the extensive scientific and psychosocial implications presented by HIV infection/AIDS in women, children and families, and bearing in mind the need to consider the problems of AIDS in mothers and children in the light of a broad approach to the health of women, children and families and the goal of Health for All by the Year 2000;

Recognising that the AIDS pandemic – closely associated with problems of drug abuse – has a particularly adverse effect on women and children, and that they are both increasingly exposed to the risk of HIV infection and also suffer extensively from the social and economic impact of HIV infection/AIDS;

Recognising that the deterioration of the economic situation in many countries adversely affects the health and social status of populations, and in particular, that of women and children;

Recalling the recent adoption of the Convention on the Rights of the Child, the resolutions of the United Nations General Assembly, the World Health Assembly, and the London Declaration of January 1988 on AIDS prevention and, in particular, the need to respect the human rights and dignity of people infected with HIV, their families and those with whom they live;

Acknowledging the leading role of the World Health Organization in the guidance and coordination of AIDS education, prevention, control and research and noting with appreciation the efforts of the World Health Organization/United Nations Development Programme Alliance, United Nations Population Fund, United Nations Children's Fund, United Nations Educational, Scientific and Cultural Organization and other intergovernmental organizations in contributing to the implementation of the Global AIDS Strategy;

Emphasising the efforts of national AIDS programmes and the role of governments, non-governmental and voluntary organizations, and the public and private sectors in implementing the Global AIDS Strategy at all levels;

Considering that the prevention and control of HIV/AIDS for women and children requires strengthening and improving the primary health care system, education, and other psychological and social support programmes for women, children and families;

Campaign against the AIDS risks of drug abuse in the United Kingdom.

Therefore, given the urgent need to promote and protect the health of women, children and families, *we appeal* to all governments, the United Nations system, within which the World Health Organization has the responsibility of directing and coordinating the global fight against AIDS, intergovernmental and non-governmental organizations, the scientific community, health and social professionals and the public at large:

1 To assume leadership and to mobilise the necessary resources, both human and financial, to actively support the prevention and care of HIV infection/AIDS in women and children, particularly in those countries that are most affected and with the greatest economic need, and in conformity with the Global AIDS Strategy.

2 To enhance the role of and the social economic and legal status of women and children; to ensure full participation of women in AIDS programmes at all levels; and to respect the human rights and dignity of women and children, including those who are HIV-infected.

3 To further develop and implement innovative, multi-faceted health education programmes for prevention of HIV infection/AIDS. Information and education programmes for and by young people, including adolescents, should emphasise their responsibilities to prevent the spread of infection to themselves and in their role as future parents.

4 To emphasise the need to prevent stigmatization and discrimination against people with HIV infection/AIDS and those at risk, in all areas of life and for all services, including school.

5 To ensure adequate recognition of the problem of AIDS and HIV infection for all affected populations by developing and maintaining effective national epidemiological surveillance and case reporting systems.

6 To ensure that the HIV/AIDS prevention and control programmes be coordinated or integrated with all other programmes for women, children and families, particularly maternal and child health, family planning and sexually transmitted disease control programmes, and to review and strengthen the policies and management of the health and other social services with due consideration to women's perspectives.

7 To ensure that HIV testing is offered to women and children as an integral but voluntary part of health programmes, including counselling and other psychosocial support, with due respect to confidentiality.

8 To promote safe motherhood for all women and ensure that HIV-infected women receive appropriate information and have access to health services, including family planning, counselling and other psychosocial support so that they can personally make informed decisions about childbearing.

9 To ensure that HIV/AIDS prevention and control programmes provide necessary support for families affected by HIV/AIDS by mobilizing health and social services to respond to emerging needs, including for families that suffer discrimination, that are not able to provide child care, or for those children who are abandoned or orphaned.

10 To emphasise availability of and access to necessary health care, including treatment, and to other social and support services for HIV-infected women and children, including recommended immunizations.

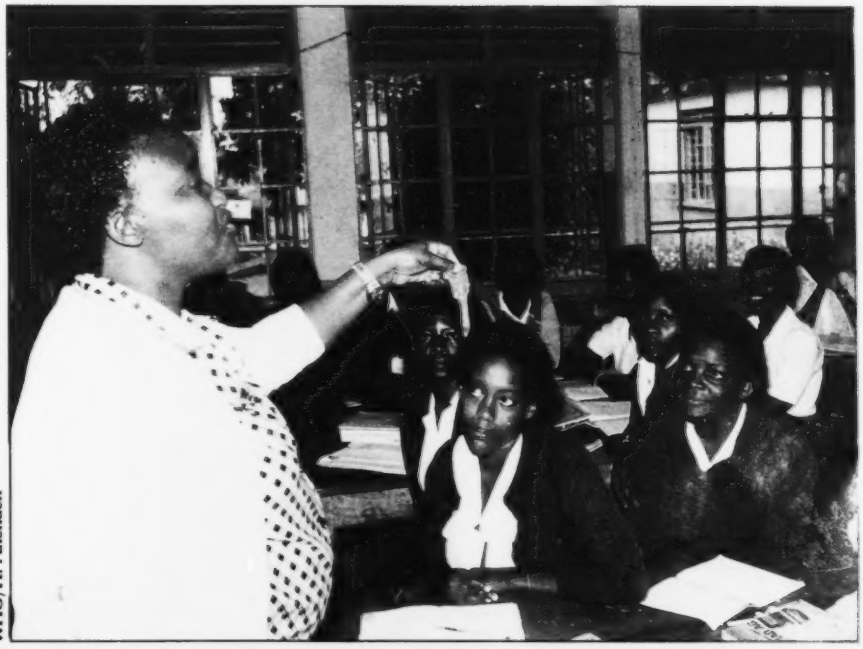
11 To continue to promote, develop and support programmes for breast-feeding as a basic component of a sound health and nutrition policy.

12 To ensure adequate and safe blood collection and transfusion services, including use of appropriate screening tests and indications for transfusion.

13 To recognise the close link between HIV infection/AIDS and drug abuse, which increases the risk of HIV transmission, and to assure availability of comprehensive health care, including drug abuse treatment and prevention programmes to minimise the risk of HIV infection of men, women and unborn children by this route.

14 To ensure that appropriate priorities and resources are devoted to research on HIV infection/AIDS in women, children and families, and to develop joint research programmes, including programmes on prevention, diagnosis, treatment, medical care and the broader related issues affecting health and social conditions of women and children. The research should also focus on the alternative approaches to providing health and other social services for HIV affected women, children and families.

15 To recognise the crucial role of women in the Global AIDS Strategy and to accelerate the process of empowerment of women against AIDS.



WHO/H. Anenden

The Paris Declaration appeals for efforts to "promote safe motherhood for all women and ensure that HIV-infected women receive appropriate information." Also "to provide necessary support for families affected by HIV/AIDS . . . and child care for those children who are abandoned or orphaned."

WHO/J. Hernandez-Claire

Psychological and social consequences

by Professor Margaret C. Heagarty
Director of Pediatrics, Harlem Hospital Center, New York

AIDS, as no other biological event of this century, has placed the world's scientific, medical and public health systems under enormous stress. After more than a century of scientific and medical progress, victory over infectious disease was declared to be within our grasp. Smallpox had disappeared, antibiotics mastered bacterial diseases, and vaccines prevented the most common childhood viral infections. All that remained was to use these new scientific wonders in underdeveloped areas of the world and the ancient scourge of infectious disease would become no more than a chapter in the history of science.

Now, almost ten years after the human immunodeficiency virus presented itself, it is evident that the world's public health system must re-examine old principles and learn new lessons about the care of communities, families and individual patients afflicted with a serious, chronic, lethal infectious disease, for which no ultimate cure or prevention is in immediate view.

But AIDS is surely more than a puzzling infectious disease; its effects on those afflicted transcend symptoms, signs and proposed therapies. This disease, perhaps more than almost any other, affects profoundly the families and communities in which those with AIDS live. And the psychological and social consequences of this disease are especially difficult for women and children.

A child is often the first in a family to manifest the signs and symptoms of HIV disease. Except in the instance of transmission by contaminated blood products, AIDS in children is a congenital infection in which the HIV virus is transmitted from mothers to infants during the perinatal period. Thus parents often must face the reality of a serious, probably lethal disease in their child at the same time that they learn that the mother and often the father are also infected with the virus.

The reactions to death or its imminent possibility have been well described: denial, anger, bargaining, depression and finally acceptance. But several factors make this process even more complicated in families coping with AIDS. First, issues of guilt and blame may play a large role in the family's reaction to the disease. Women, infected by men, may blame their partners for their infection and for the disease in their child. The conflict in a marriage and family in this situation can cause serious and sometimes permanent disruption of a family unit. Moreover, guilt is the ordinary human response of a parent to any illness in one of their children. So a mother who has infected her child during pregnancy must cope with that guilt even while she deals with serious disease in herself and her child.

In addition, in certain parts of the world AIDS in women and children is caused through infection by contaminated needles used in illicit intravenous drug use. At best, drug-using parents are marginal in their ability to care for children. The presence of AIDS in drug-using women and their children may result in such worsening of their social disorganization as to destroy their ability to care for any of their children, either well or ill.

Furthermore, the overwhelming medical and psychological needs of women and children with AIDS may result in the neglect of the other children in these families. But these

Strong family bonds in a West European city. More than almost any other disease, however, AIDS profoundly affects the families and communities in which people with AIDS live.

children – who are often obliged to take over many of the parental responsibilities – must face the death not only of their sister or brother but of one or both of their parents as well. Unless these children are provided with considerable sensitive support, their natural feelings of guilt, abandonment and loss will inevitably damage their development and their ability to cope.

The serious psychological and emotional effects of this disease on family functioning are further complicated by the social stigma and discrimination associated with AIDS. Even after almost ten years of widespread public education in some countries about AIDS, many unfortunately continue to discriminate against, to penalise and to shun those with the disease. Because of fear and rejection on the part of the larger community, families with AIDS may feel they must and indeed may be required to keep the fact of the disease secret from their extended family, friends and neighbours. The resulting isolation comes at a time when the family is in greatest need of external support and care.

A majority of women and children with AIDS are poor. Poverty brings with it problems of housing and food, as well as of access to medical care or social services. The AIDS epidemic in women and children has pushed the medical and social services of communities in which the disease is prevalent to a point of genuine crisis. The ability of these systems to care for an ever-increasing number of patients with this serious, lethal disease is so imperilled as to place in jeopardy the entire medical and social systems working for the poor of these communities.

Orphaned children

Ultimately, as the disease progresses and as many women begin to die of AIDS, their families and their communities will be confronted by an increasing number of orphaned children for whom they must be responsible. In the best of circumstances, extended families will take responsibility for these children; but in many instances extended families may not be available or willing to assume this responsibility. In this situation, permanent foster care or adoptive arrangements should be the goal for these surviving children. But some communities may be faced with the necessity of developing small group homes for some surviving children of parents with AIDS. In this crisis those of us in developed countries must be careful not to repeat the mistakes in child welfare of earlier generations. The dangers of "institutionalising" children have often been described. Hence any such arrangements must be small, personal and carefully monitored, lest we unnecessarily damage large numbers of children irreparably.

A striking study of father and child. And supposing the mother had proved HIV-positive, or had died from AIDS?

The enormity and complexity of the social and emotional consequences of AIDS on women, children and families will test the ingenuity and commitment of those medical and social services practitioners who are responsible for their care. But the rewards of this care are large, for no group within our practices are in greater need.

As we attempt to find ways to provide medical care, solace and social support for these families, we truly fulfill our ancient roles as physicians, nurses, social workers and public health practitioners. Moreover – since this epidemic has crossed all national boundaries from the developed to the developing world, AIDS offers us a unique opportunity to learn from one another as we devise new solutions and programmes for these women and children. We should be careful not to lose this opportunity to support one another as we struggle to understand the disease and its social and psychological effects on individuals, families and communities. ■

From a Uganda casebook

by Mrs Noerine Kaleeba
Founding Director of TASO, Uganda

Since AIDS crossed my front door four years ago and took my husband away from me, I have dedicated my life to working with people and families with AIDS. Two years of experience working with The AIDS Support Organization in Uganda (TASO), which I co-founded, have convinced me that, although HIV in the Third World and Uganda in particular is heterosexually transmitted and affects men and women in equal numbers, the psycho-social issues for mothers and their children are more profound. Consider the following two scenarios:

– *Eighteen-year-old Naiga comes to TASO for counselling. She is very anxious about herself and her boyfriend with whom she has been going steady for six months. They have been having unprotected sexual intercourse; she is on the contraceptive pill. From the long agitated story, the counsellor draws out that Naiga wants to have a baby now, prove her fertility to her fiancé, and subsequently pursue marriage. She has read all that there is about HIV infection, particularly with regard to mother-to-child transmission. She even knows about a small study done in Uganda which put the chances of infection at 25 to 30 per cent. She sounds very determined to have this baby, but it will kill her, she says, if her baby turned out to be infected or ill in any way.*

Encouraged by the counsellor, Naiga reveals that a married man with whom she had had a brief affair a year ago has "Slim" – a common African name for AIDS because of its wasting effect. She had never told her boyfriend about this previous affair and she cannot begin to tell him now. Musisi, her boyfriend, is putting increasing pressure on her to have this baby. Does Naiga know anything about the HIV antibody test? Yes she does! But she does not want to take the test as she is not sure she could stand being told that she is HIV positive. Right now she fears she probably is HIV-infected and will go on to develop AIDS, but this remote possibility is not her immediate concern. She wants to become the mother of a healthy baby. She must give her man a healthy baby, consolidate their love and work towards marriage.

"I don't know whether I am fertile or not, and I need to know that. I don't wish to marry and later on find out that I cannot have children." She also needs to be assured that the father of her child will remain healthy so that they can both bring up the child. She has always disliked the idea of single mothers and believes a child should be brought up by both parents. If she is infected, then she must not infect her boyfriend, the future father of her child! But how does she introduce the idea of safer sex?

Musisi, her boyfriend, has always declared that "non-penetrative sex" is not sex and she agrees with him. The only alternative would be to negotiate the use of a condom, but how does she do so without arousing his suspicions? The only discussion they have ever had about sexual matters was to do with having babies and he has always been agreeable to her taking the pill. This has never been his concern since she is responsible for taking the pill and protecting herself from unwanted pregnancy. Now that the time has come, it is her responsibility to bear him children. They both want this child, so how can she begin talking about the condom or even be thinking of using a condom? She wants the child as much as her boyfriend does. Condoms and babies don't go together!

She feels she has betrayed her boyfriend by having had an affair before they met. She cannot even begin to discuss her fears about HIV with him, as it is generally believed that the first person to worry about it is the guilty one. Women are to blame in the majority of cases, anyway!

– The second scenario concerns Nambi, a third wife and the mother of six young children.

Her children have always been healthy and, thank God, she and her two co-wives have each been responsible for their own children's health. Eighteen months ago, her sixth child, Mukasa, was born prematurely. This she believes was the result of a quarrel she and her co-wife had had the day before. Her co-wife had threatened her

Health education campaigns in Uganda are aimed at girls as well as boys.

WHO/E. Hooper

WHO/E. Hooper

Young women thinking of having children may often have hard decisions to make.* Right: *A grieving father carries the body of his son, dead from AIDS, for burial.

with witchcraft. She was not surprised therefore when the labour pains started and the baby arrived four weeks before term.

The weeks she was in hospital with the baby in special care left all her gardens overgrown with weeds. Food therefore has become scarce. The baby has been in and out of hospitals, with intermittent fevers, diarrhoea, vomiting and a subsequent failure to thrive. Her other children are badly neglected by her, as she is often exhausted, irritable and frantic with worry about Mukasa's health. The last doctor she saw referred her to Dr Hanny Freisen, the paediatrician who will examine the child's blood and treat the child accordingly.

Dr Freisen runs a weekly paediatric AIDS clinic. Before seeing the doctor, mothers are given pre-test counselling by the TASO counsellor.

Nambi has good information about HIV, the way it is spread and how to avoid getting infected. She knows the signs and symptoms, many of which her baby has had. A suggestion that her baby might possibly be infected is vigorously denied. The possible source of infection is gently examined with her by the counsellor, and the possibility that she herself might have passed the infection to her baby is even more vigorously denied. She has had sexual relations only with her husband for the last 12 years. She had had a normal pregnancy, and if it had not been for the witchcraft from her co-wife, Mukasa would have been born at full term. She consents to a blood test and both her blood and Mukasa's is tested. The results are positive for HIV antibodies.

What do these stories suggest? The Naiga story highlights the fact that, when thinking about having a child, an HIV-infected woman makes a hard decision based on several factors:

– In aspiring to conceive, she risks infecting her partner;

– She risks transmitting the infection to her unborn baby;

– Even if the baby was not infected, this young mother risks falling ill and probably dying, thus leaving her very young baby orphaned.

In Uganda and many other African countries, girls are having babies much later, because more educational opportunities are now available. Yet statistics coming out of Uganda show that girls are getting infected at a much younger age than boys. This means that the girl may be infected before she has even had one child. And yet having children is more important to women, since failure to have them can never be attributed to a man. It is always the woman who is barren!

From the Nambi story we realise the following:

Mukasa has AIDS and will probably not see his fifth birthday. His brothers and sisters meanwhile suffer neglect. He was infected by his mother who is apparently healthy.

How can she explain?

Because she has never even remotely connected herself with HIV infection, she readily consents to a blood test. But when the results come out positive, she is not only shocked, she is absolutely lost to know what to do. How can she even begin to explain to her husband? And what about her co-wives?

Because it has never been made clear to her, she does not know the difference between HIV infection and AIDS (Slim). She is devastated. She has slim. She is going to die. The world will know, and her co-wives will laugh at her. ■

A caring society

by Sir Donald Acheson

Chief Medical Officer, Department of Health and Social Security, United Kingdom

WHO currently estimates that eight to ten million adults in the world are infected with HIV, of whom three million are women. In addition, over half a million children are HIV-infected.

In the developing world, the main route of transmission of the virus is through vaginal intercourse, while in many industrialised countries the numbers infected through injecting illicit drugs and through vaginal intercourse are increasing. The conclusion we must draw, as the epidemic continues to spread, is that not only will the number of women who become infected inexorably rise but so will the number of children. It is at present estimated that about one quarter of babies born to infected mothers are themselves infected with HIV.

The daunting forecasts are that 200,000 women worldwide will develop AIDS during 1990 and 1991 alone. This not only represents a profound personal tragedy for the affected women and children; it will also have a profound impact on the family and society as a whole, since the traditional woman's role within the family of carer and mother will no longer be fulfilled.

Society has a duty to respond to this tragedy. One overriding responsibility must surely be to exert every effort to reduce its scale to a minimum. Public opinion must be focused on the issue and renewed efforts must be made to educate both men and women about how to protect not only themselves but others from the spread of this lethal virus. Where there is neither cure nor vaccine, prevention is the only alternative.

But society also has a major, and no less important, responsibility towards those who are already HIV positive. The key principle is that all infected people, including mothers and children, must enjoy the same basic human rights as uninfected people. Further, they have the right not to be discriminated against or stigmatised in any way – and that includes housing, education or employment. They should have the right to travel as freely as they wish and the right to confidentiality and privacy. They also have the right, according to their needs, to all the support and services due to other vulnerable and sick people.

No need for quarantine

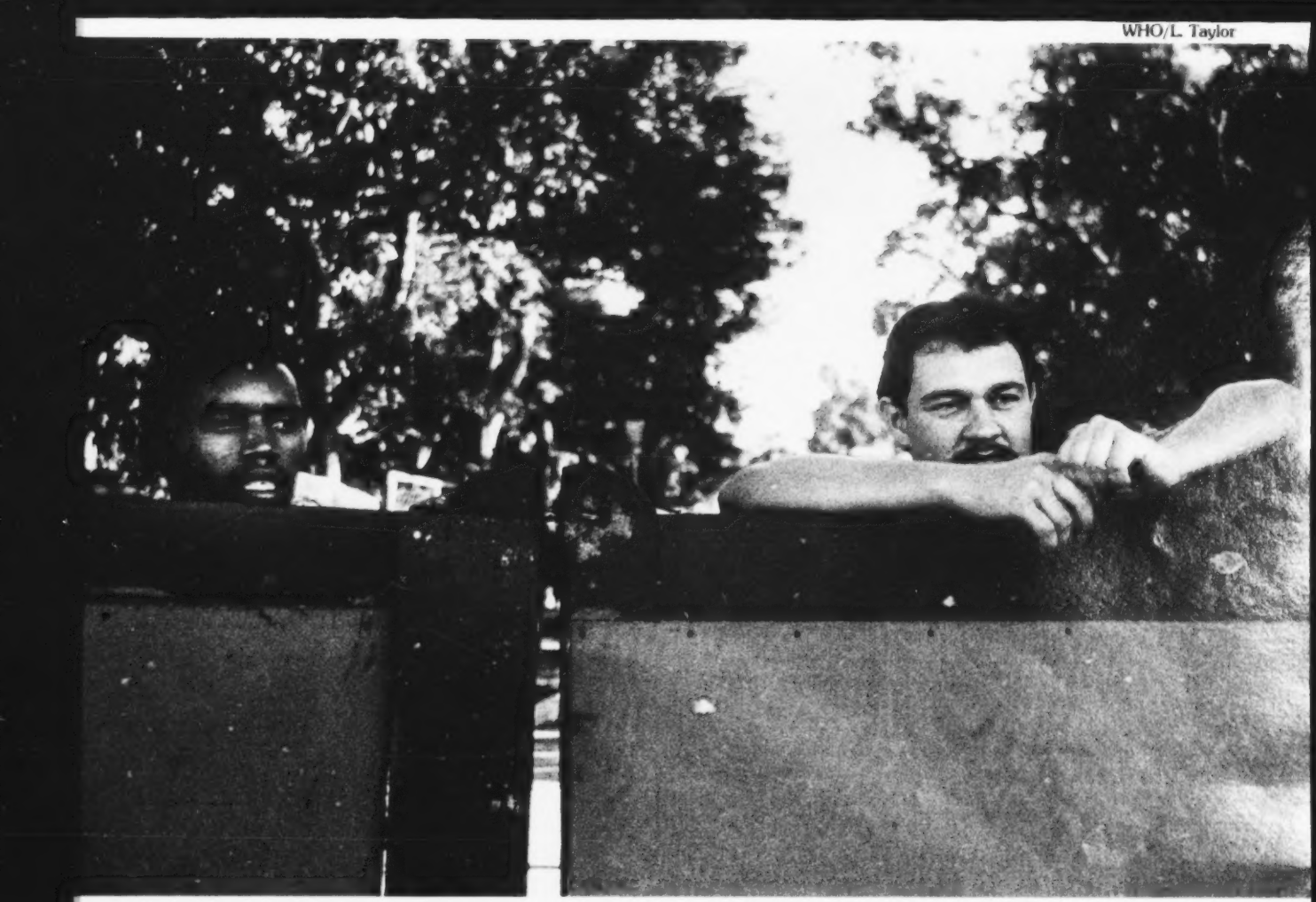
As infection with HIV is only transmitted in three ways – by sexual intercourse, by blood and from mother to baby – there is no rational basis for subjecting mothers and children who have this infection to quarantine or any other type of sanitary restriction. Whenever possible, health care and social support for people with AIDS-related illness should be administered within the general provisions for such care. Measures specifically directed at HIV and AIDS, however well intentioned, may themselves lead to stigmatisation.

There are also serious social implications. In those areas where the prevalence of HIV among young women has been very high for a decade or more, a devastating picture is already being seen. In parts of Africa, there are many villages where only orphaned children and the very old remain. All the mothers and fathers are dead or have fled. This encapsulates the unique horror of HIV within the family. Many of the parents will die while their children are young, and provision must be made not only for sick and dying children but for the majority who, uninfected, will survive as orphans. WHO estimates that more than ten million young children (less than ten years of age) are expected to be AIDS-related orphans in Africa during the 1990s. Society has a responsibility to all – the mothers, affected children and orphans alike.

Even in the minority of countries where women have won equal rights,

WHO

Nurses in Thailand attending a workshop on AIDS prevention. Health care and social support for people with AIDS should be administered within the general health services.



WHO/L. Taylor

Patients at an AIDS sanatorium in Cuba. "As members of society, we all have a responsibility to ensure that those infected with HIV are not discriminated against."

HIV-infected women still face discrimination. In the majority of countries, where they have not won those rights, their plight is correspondingly worse. In many cases women have been infected by a partner of whose risk they have been unaware. If they know they are infected and become pregnant, they face the awesome choice whether to continue with a one-in-four chance of bearing an infected baby or to undergo the trauma of a termination of pregnancy. They may already be members of groups – such as injecting drug users – for whom society has little sympathy, or they may be abandoned by their partners, friends and family when their infection is discovered. They face illness and probable early death. They also feel guilt and face blame – but who among us dare cast the first stone? In such circumstances it is not surprising that they frequently cannot care for their children.

Society must give these mothers support at every stage. They need special advice and counselling before and during pregnancy, and afterwards support tailored to their needs. Governments have a responsibility, but cannot alone succeed in fulfilling all these requirements. So there is an important role for support groups to play, with help from non-governmental organizations, charities and other bodies.

Infected children too need help – and who can be surprised that in the worst affected areas many are abandoned and end up in long-term care in hospital? But this is a confession of failure because infected children need to be able to fulfil as far as possible a normal childhood and enjoy a parent's love and affection. Many are born into single-parent families already isolated from the wider circle of family and friends. The older ones feel the stigma of both their own and their mother's illnesses. Isolated at school and ostracised by their friends, they suffer mentally as well as from the physical effects of their illness.

"Street children"

Then there is the other tragic group of children who, having escaped infection themselves, watch helplessly as their parents and siblings sicken and die. Finally, in a slightly different context there are the abandoned children who roam the streets of our cities – but who today face the additional hazard of HIV infection through sexual abuse or intravenous drugs. It is estimated that there are no fewer than 100 million "street children" in the world.

Society must face the fact that in the immediate future it will be necessary to make arrangements for the fostering of sick and orphaned babies and children on an increasing scale. And this must be provided in a caring and compassionate atmosphere. The picture painted is a dark one, and the problems present an enormous challenge for us all. But the human spirit is such that no tragedy, however grave, fails to evoke a positive response.

As members of society, we all have a responsibility to ensure that those infected with HIV are not discriminated against, and that they receive the care and support which all sick people need and deserve. ■

A research agenda for the 1990s

by Dr Catherine A. Hankins

Epidemiologist at the Centre for AIDS Studies, Montreal General Hospital, Canada

Although more than a third of all reported AIDS cases in the world are women, research efforts concentrating on aspects of the AIDS epidemic that pertain particularly to women have been slow to materialise. So it is timely to document the most pressing research needs in the context of the worldwide effort to highlight the special problems that the epidemic poses for women.

Awareness that women were being infected came belatedly in the industrialised countries, and coincided with the first confirmation of the heterosexual transmission of HIV. From the beginning of the epidemic in some countries of Central and East Africa, men and women were affected in roughly equal numbers; nevertheless, there was delay in recognising the importance of AIDS to women because of a host of medical and non-medical factors, not the least of which is the status of women in society. Worldwide, progress was hindered by this late recognition joined with discrimination, research problems specific to women, and lack of interest.

In most countries, women are still less likely than men to be research subjects in clinical trials. The argument has been made that hormonal differences which could affect drug metabolism make studies in women irrelevant to the treatment of male patients, who constitute the majority of infected individuals in the industrialised world. Women also tend to be excluded from drug trials unless researchers can be convinced that they will faithfully practise contraception. This condition has not been imposed on infected men, even though experimental drugs may have effects on sperm production that could lead to congenital defects in their children.

Mother to foetus

An overriding concern for the foetus in many societies has meant that women who are already pregnant may be denied treatment for life-threatening illnesses. Could this be one reason why clinical trials of drugs which might reduce vertical transmission from mother to foetus are only just completing the planning stages?

Finally, there are in general fewer female than male researchers in all aspects of the HIV/AIDS research effort, and since fewer women than men are infected in Western countries, scientists have been less attracted towards pursuing studies with relevance to women.

The research areas that most deserve priority attention are sexual transmission, vertical transmission from mother to foetus, treatment and care, and the whole field of evaluation and prevention.

It has been shown that biological factors, such as the presence of genital ulcers caused by herpes, syphilis or chancroid, and behavioural factors, such as unprotected anal intercourse, can increase the risk of *sexual transmission* of HIV to women. But the interaction between various factors and their actual mechanisms of action are still not clear. The recently reported role of non-ulcerative infections such as chlamydia and gonorrhoea in facilitating transmission of HIV needs to be rapidly clarified, since control of these highly treatable diseases could be an effective and immediate method of limiting the speed of HIV spread in many countries.

A possible increased susceptibility to HIV among women who are exposed to the virus while taking the oral contraceptive pill has placed this issue

Health counselling for a drug user in Bangkok. In most countries, women are still less likely than men to be included in clinical trials.

WHO

WHO/H. Anenden

Grouping blood samples at the Kenya Blood Bank in Nairobi.

high on the research agenda for women. Although the additional risk may be small, it is important that it be defined. Women want to be able to make informed decisions about whether to rely on condoms, the intra-uterine device or other contraceptive methods for birth control in addition to condoms for STD prevention.

What little research has been conducted on the effect of spermicide use on HIV transmission has produced contradictory results. Studies are urgently needed to determine whether spermicides may actually cause irritation on the lining of the vagina which could facilitate entry of the virus into the body. The nature of male resistance to using condoms also requires close investigation.

Research to discover methods of reducing the rate of *transmission from mother to infant* is itself in its infancy; much remains to be learned both about the effects of pregnancy on HIV disease and the effects of HIV infection on pregnancy. A greater effort in this field to describe the determinants of HIV transmission during pregnancy and at childbirth may show up medical and behavioural ways in which vertical transmission can be minimised.

Vital questions

Does pregnancy precipitate a deterioration in the mother's health or does it protect her from clinical progression of her HIV disease? Is there less chance of transmission from mother to foetus if the mother has been infected for a shorter period of time? If yes, would it not be preferable for women who want a baby to become pregnant earlier rather than later in their infection? Sufficient rigorous studies have yet to be conducted that will give a clear answer to these important questions.

So far, all the cases of HIV transmission attributed to breastfeeding have occurred among mother-infant pairs where the mother was not infected at the time of her pregnancy or childbirth. It is vital to determine whether breastfeeding poses an additional risk for the uninfected infant who has received maternal antibodies from his or her infected mother during pregnancy. Women need to know whether they can breastfeed safely.

As regards *treatment and care*, the natural history of HIV infection in women has not been well studied. Therefore, it is still not clear whether

WHO/J. Taylor

Rapt attention at a lecture in Mexico City. "Women want to be able to make informed decisions about methods for birth control in addition to condoms for STD prevention."

women experience shorter survival times than men. Little attention has been paid to the unique features of HIV disease in women, and in particular to gynaecological complications such as vulvo-vaginal candidiasis, also known as yeast infection. Cohort studies in which groups of infected women are followed over time would help describe the clinical course of HIV in women. Hormonal influences on drug metabolism too have not yet been clearly described.

Little clinical research which might benefit women subjects is currently being carried out in Africa, largely because of the high cost and, as a result, few treatments are available for more than simple symptomatic relief. Clinical trials of appropriate medical interventions would serve the critical dual purpose of advancing scientific knowledge directly relevant to a developing country setting while providing care which otherwise would be unavailable.

In most societies, women undertake the lion's share of both professional and domestic care-giving. They must attend to the immediate needs of infected partners, of their infected and non-infected children, and of dependant elderly family members, in spite of the ravages of their own HIV infection. Studies are urgently needed that can show the effectiveness, both in developing and in developed countries, of care techniques to ease discomfort and provide symptomatic relief for non-curable complications. Research could also show how medical services, traditional healers, and home and community supports could interact in different cultural and economic settings so as to share more effectively the burden of care-giving.

Safer sex

Prevention research is essential to evaluate the effectiveness of behavioural, biological, administrative and other strategies in preventing HIV transmission. Programmes aimed specifically at women need to be scientifically assessed to determine the factors affecting safer sex behaviour in women. How can interventions for drug dependency be improved? How may prostitutes be assisted to protect themselves from HIV transmission, or to obtain support if they desire to leave the sex industry?

Vaccine development is of crucial interest to women for the prevention of both sexual transmission and vertical transmission from mother to child. Studies of vaccine efficacy involving women will most likely be conducted in African and Caribbean countries with high rates of these forms of transmission. Research in the 1990s must also focus on reducing blood transfusions associated with childbirth and decreasing the use of inadequately sterilised injection equipment. Programmes to reduce nutritionally-induced iron deficiency or to combat chronic malarial infection can help to cut down on blood transfusions, with their inherent risk of HIV infection. Such studies are particularly relevant to women in non-industrialised countries.

The focus that the 1990 World AIDS Day is putting on women allows researchers, educators, patients, care-givers and funding agencies alike to reflect on the urgent research priorities that will affect most women. Positive action is essential now to reduce the current shortfall in research and to stimulate research efforts that will have immediate and long-term application to women. ■

World AIDS Day 1990

by Mr Thomas Netter
Public Information Officer, WHO, Geneva

For the third consecutive year, WHO is spearheading the planning of World AIDS Day on 1 December to focus attention on the global AIDS epidemic and stimulate activities around the world. This highly successful event, which since 1988 has brought special messages and information about AIDS to every country in the world, will this year have the vital topic of "Women and AIDS."

"Women are the key to achieving health for all," says Dr Hiroshi Nakajima, Director-General of WHO, in designating women as the special focus for World AIDS Day activities in 1990. He has called on health ministries of the 166 member states of WHO to arrange events and observances as part of a growing effort to further expand public awareness and knowledge about the impact of AIDS and human immunodeficiency virus on women.

As outlined by the Director-General, the four objectives of the Day are:
– to continue increasing awareness about HIV/AIDS;
– to strengthen the worldwide effort to stop AIDS by highlighting the impact of HIV/AIDS on women everywhere;
– to support the strengthening of AIDS prevention and care activities and programmes at all levels, with particular attention to women's special needs;
– to promote the support and care for all HIV-infected persons and people with AIDS, their families and friends, and to combat discrimination and isolation.

More events than ever before are expected this year, undertaken by WHO, health ministries, non-governmental organizations (NGOs) and community groups. This is due to the worldwide network of World AIDS Day organizations created over the past three years. The first World AIDS Day in 1988 emphasised communication and global mobilisation against AIDS. In 1989 the second Day underlined the importance of youth in combating the epidemic. And in 1990, WHO is calling attention to the increasing problem of the disease among women around the world.

One-third are women

WHO estimates that, up to this year, at least eight to ten million adults are now infected with HIV and that some three million – or approximately one-third – are women. About 500,000 people will develop AIDS during the years 1990-91, including around 200,000 women. The number of women expected to become ill with AIDS during the next two years will exceed the cumulative total of all the AIDS cases reported to WHO during the first decade of the epidemic.

What is the global prevalence of HIV infection among women? While the majority of infected women are in sub-Saharan Africa, HIV prevalence in different areas of the world ranges from a high of about one infection for every 40 women to a low of less than one infection for every 20,000 women.

AIDS has always had a profound impact on women, both as an illness and as a social and economic challenge. Women play a crucial role in preventing infection with HIV and in caring for HIV-infected people and people with AIDS. In addition, the vulnerability of women to HIV infection and to the serious consequences of the epidemic can be heightened in many cultures by a lack of status within the family and society. The stigma attached to AIDS may subject women to discrimination, social rejection and other violations of their rights.

World AIDS Day events will draw attention to these special problems and will highlight the need to involve more women in the global fight against

Young people enthusiastically participate in each successive World AIDS Day at the Geneva headquarters of WHO.

WHO/T. Farkas

AIDS. This effort is an integral part of the broad area of health and development, particularly at the country level, and Dr Nakajima has encouraged activities aimed at realising these goals.

The Day will also seek to emphasise the link between the status of women within the family and society, and their vulnerability to infection and its consequences. It will draw attention to the special concerns relating to HIV/AIDS and pregnancy, childbirth and raising children; involve women and women's organizations in arranging events; strengthen information and education activities for women at all levels of society; and stress the importance of programmes on AIDS and women as part of national development activities.

Millions of people around the world participated in the World AIDS Day last year, when it focused on young people and AIDS. Events and observances held in over 160 countries made World AIDS Day 1989 the largest coordinated global day of information and activities against HIV/

What is World AIDS Day?

World AIDS Day is an annual day of observance designed to expand and strengthen the worldwide effort to stop this disease. It means talking about HIV infection and AIDS, caring for people with HIV infection and AIDS, and learning about AIDS to sustain and reinforce the global effort to stop its spread.

The Day is intended to open channels of communication, strengthen the exchange of information and experience, and forge a spirit of social tolerance. Each year, it is the only international day of coordinated action against this disease around the world.

World AIDS Day highlights AIDS prevention and control activities already under way and forges new links in the struggle. It is now a yearly event in most countries, helping to build a lasting worldwide effort to stop AIDS.

For more information about this event, or if you wish to be included on the WHO mailing list for World AIDS Day materials, write to World AIDS Day, GPA/PIO, World Health Organization, 1211 Geneva 27, Switzerland.

AIDS ever held. It built a lasting foundation for vastly expanded future activities against AIDS in many countries.

This year, WHO will hold a special consultation on the issues of women and AIDS on 30 November and 1 December at its Geneva headquarters. A previous consultation with international women's non-governmental organizations (NGOs) held in Geneva last December recommended that such a meeting should be convened. On this occasion the consultation will provide a substantive forum for enlarging on the chosen theme, and will involve specialists in this issue from many countries. In addition to the discussions there will be exhibits of photos, posters and other materials by and about women.

These events will be the culmination of a year of efforts at WHO focusing on the profound problems and needs of women in this epidemic. An international meeting co-sponsored by WHO in Paris last November, on the implications of the disease for women and children, produced the first global declaration about the needs of women and children in the history of the AIDS pandemic. In May 1990, the World Health Assembly, WHO's governing body, adopted a similar resolution.

"Radio watch"

WHO will release a special media feature on women and AIDS, and will begin a 24-hour "radio watch" at 00h01 on 1 December (Saturday) to formally inaugurate the Day, continuing throughout the day to provide interviews to radio stations around the world. Women in the media will be invited to provide special news coverage of events, and there will be a series of video reports on the impact of the disease on women. ■

Left: ***Some youngsters added their heartfelt messages to a large "notice board" laid on the floor at the entrance to WHO. Others (below) joined the audience to hear testimony from Richard Rector, himself a person with AIDS.***

WHO/T. Farkas

NEWSPAGE

Editor: Philippe Stroot

World Health Day in Iran lasts a year

In common with most countries of the world, Iran commemorated World Health Day – on 7 April 1990 – with its slogan "Our planet, our health: think locally, act globally." But Iran chose to consider the theme of environmental health as lasting for the entire year, not just one day.

Three months before the Day, representatives from all the institutions relating to the environment met in Teheran to coordinate their activities. They included the ministries of health, of the interior, of industry, of power, as well as the University School of Public Health and the Organization for Atomic Energy.

On 7 April, a two-day seminar began in the biggest hall in Teheran to discuss frankly where the environment was being ill-used and what concrete measures could be taken to improve the situation. Similar seminars took place in several provincial capitals.

The Minister of Health and heads of other institutions, as well as the Mayor of Teheran, went on television and radio to alert the general public to dangers in the environment, and to explain how environment interacts with health.

According to Mr H. Salmanmanesh, Director-General of Environmental Health in the Health Ministry: "Teams of technicians and food experts fanned out through the city to oversee the serving of food and standards of hygiene. They closed more than 80 shops a day because they failed to reach the standards. Only when they can show that they have taken steps to come up to standard can they re-open."

He went on: "There has been heavy pollution in Teheran. So we banned large trucks from entering the city between 5 a.m. and 9 p.m. This eased the traffic and cut down the pollution. Cars that put out too much smoke are stopped by the police and warned to have the engine tuned or risk losing their licence. People have told me they can actually see the improvement in the form of clearer visibility.

"Once a week all year, a special television programme is screened called The Way to Health; it uses the front cover of the January-February issue of *World Health* as its symbol.

"Meanwhile in the villages, the Health Houses (primary health care posts) became the focal points for garbage collection and cleanliness drives, run by the villagers themselves. People were encouraged to build latrines by being given the porcelain slab free of charge. The response was very positive."

Iran also convened seminars on chemical safety, control of insect vectors of disease and safe sewage disposal. Mr Salmanmanesh hopes similarly to make World Health Day 1991, with the slogan "Should disaster strike – be prepared," last for the whole year. It has particular relevance for Iran – which was hit by a disastrous earthquake in June. ■

The end of the line for guinea worm?

The total eradication of guinea worm (dracunculiasis) has been brought another step nearer. In August, during the 26th Assembly of Heads of State and Governments of the Organization of African Unity (OAU) in Addis Ababa, former United States President Jimmy Carter summed up the world situation of this disease. He stressed the urgent need for all endemic countries to carry out an active search for cases at the national level so as to evaluate the importance and spread of the disease, and urged the political leaders to lend vigorous support to national eradication programmes.

President Carter also held a private session with the leading politicians of seven French-speaking countries – Bénin, Burkina Faso, Côte d'Ivoire, Mali, Mauritania, Niger and Togo. Also present were Dr G. L. Monekosso, WHO's Regional Director for Africa, Mr Djibril Diallo, Adviser to the Executive Director of UNICEF, and Dr Donald R. Hopkins, Senior Consultant to "Global 2000" (the institute based in Atlanta, USA, which is supervising the drive to eradicate guinea worm).

Guinea worm is spread by drinking contaminated water.

WHO/J. Magee

The interest shown by the political leaders in solving this problem is a good omen for the future, since the obstacles to wiping it out are not of a technical order but depend essentially on the political will and the social and economic conditions of the endemic countries. Often overlooked at the government level, this debilitating disease particularly strikes at isolated farming communities.

Thanks to remarkably well-run national programmes, India and Pakistan – the only two countries of Eurasia that are still endemic – have high hopes of eradicating the disease by next year or 1992. But this is not yet true for sub-Saharan Africa, where the disease is endemic in 18 countries and threatens some 120 million people.

In 1989, only four countries undertook active surveys on a national scale: Cameroon reported 871 cases, Ghana 179,670, Kenya five and Nigeria 640,008.

The firm commitment of the seven countries of Francophone Africa should make it possible to attain the target set during the 38th session of WHO's Regional Committee for Africa, held in Brazzaville in September 1988, and confirmed in March this year at the Third Regional Conference on Guinea Worm in Africa, held at Yamoussoukro, Côte d'Ivoire: the total eradication of guinea worm by 1995. ■

Consultation on Eastern Europe

Rapid political and social changes in Central and Eastern Europe have thrown into relief certain specific health problems. Some countries have reported rates of infant mortality and of deaths from all causes that are among the highest in Europe. The environment is in poor shape, and there have been dramatic reports about declining health among residents.

Reflecting the growing concern about this situation, WHO convened an informal consultation in Geneva in August, attended by ministerial delegations from Bulgaria, the Czech and Slovak Federal Republic, Hungary, Poland, Romania

"Don't throw the baby out with the bath water . . ."
Therapy at the Peto Rehabilitation Institute, Budapest.

and Yugoslavia, as well as representatives from the UN Development Programme and the World Bank.

Opening the meeting, WHO Director-General Dr Hiroshi Nakajima observed that, despite the grave situation in some of their countries, the serious problems of the developing world, especially of the poorest countries, should not be forgotten. He recalled the contribution that the countries of Eastern Europe had made to the developing world, either directly or through international organizations, notably in the form of human resources or supplies of pharmaceuticals and equipment.

Several participants echoed these comments; they warned that the countries should "not throw out the baby with the bath water," but should preserve existing structures so as to build on them new and more efficient systems. They devoted special attention to financing the restructured health systems.

Referring to the current détente in the world, Dr Nakajima said: "If only a fraction of the sums previously spent in the arms race could be devoted to financing social development, especially the health systems of countries in need, there will be dramatic improvements in levels of health. Considering the wave of change which is sweeping the world, this is surely not an unrealistic hope."

Following the consultation, a global task force on health development in countries of central and eastern Europe has been formed. ■

Newsbriefs

• **Safety on the roads:** *WHO and the Indian Institute of Technology are co-sponsoring an International Conference on Road Safety to be held in New Delhi from 27 to 30 January, 1991. Specialists in traffic accidents and safety measures will discuss the most effective and economical means of curbing the present disastrous toll of deaths and injuries that afflicts most countries of the world. Particular attention will be given to pedestrians, cyclists and motorcyclists, and bus passengers.*

• **Guidelines on water safeguards:** *PEEM, the Panel of Experts on Environmental Management for Vector Control (a joint activity of WHO, FAO and UNEP), has published two booklets targeted at policymakers and planners involved in water resources.* Guidelines for the incorporation of health safeguards into irrigation projects through intersectoral cooperation *examines the links between irrigation and health.* Guidelines for forecasting the vector-borne disease implications of water resources development *considers the vulnerability of communities to infection, the risks of transmission, and the capacity of the health services to cope with new risks. The documents can be obtained from the PEEM Secretariat, CWS, WHO, 1211 Geneva 27, Switzerland.*

• **People Power against AIDS:** *The Third International Symposium on AIDS Information and Education, to be held in Manila, Philippines, 2 to 7 February, 1991, will have as its theme "Health Promotion in Action". Organized by the Philippines Department of Health and WHO, and co-sponsored by UNESCO and UNICEF, the Symposium will bring together experts and interested parties to exchange and develop knowledge and techniques in promoting awareness and prevention of HIV infection and AIDS. "Our people are often identified with People Power," said the Philippines Secretary of Health, Dr Alfredo R. A. Bengzon. He added: "An important aspect of empowering people is providing them with information necessary to improve their own lives. Such is the thrust needed in fighting AIDS today."*

• **Supportive health promotion:** *Organized by WHO and the Nordic countries on the theme of Supportive Environments for Health, the Third International Conference on Health Promotion will be held in Sundsvall, Sweden, next June. Some 300 participants will come from developing and industrialised countries, and it is hoped that men and women will be in equal numbers. The theme was inspired by WHO's Health for All strategy and the UNEP thrust for sustainable environmental development. The Conference will seek ways to create physical, social and economic environments supportive of health in the context of sustainable development. Further information from: Third International Conference on Health Promotion, Box 290, S-85105 Sundsvall, Sweden.* ■

In the next issue

The slogan chosen for World Health Day 1991 is: "Should disaster strike – be prepared." The January-February issue of *World Health* will examine some of the ways in which we can all be in a state of readiness in case of disasters – whether natural (like floods, typhoons, earthquakes) or man-made (such as pollution, or famine resulting from warfare).

WORLD HEALTH INDEX 1975–1990

A new edition of the *World Health Index* has been prepared and will be published at the end of this year. The Index will bring up-to-date all the key subjects dealt with in *World Health* magazine between 1975 and 1990, inclusive. Published in English and French only, it will be sent routinely to all Libraries on our mailing list. A copy will be sent free to any member of the public requesting it from: The Editor-in-Chief, *World Health*, WHO, 1211 Geneva 27, Switzerland.

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WHO also offers its "Health Horizons" combined subscriptions to both *World Health* (six issues per year) and the quarterly *World Health Forum*.
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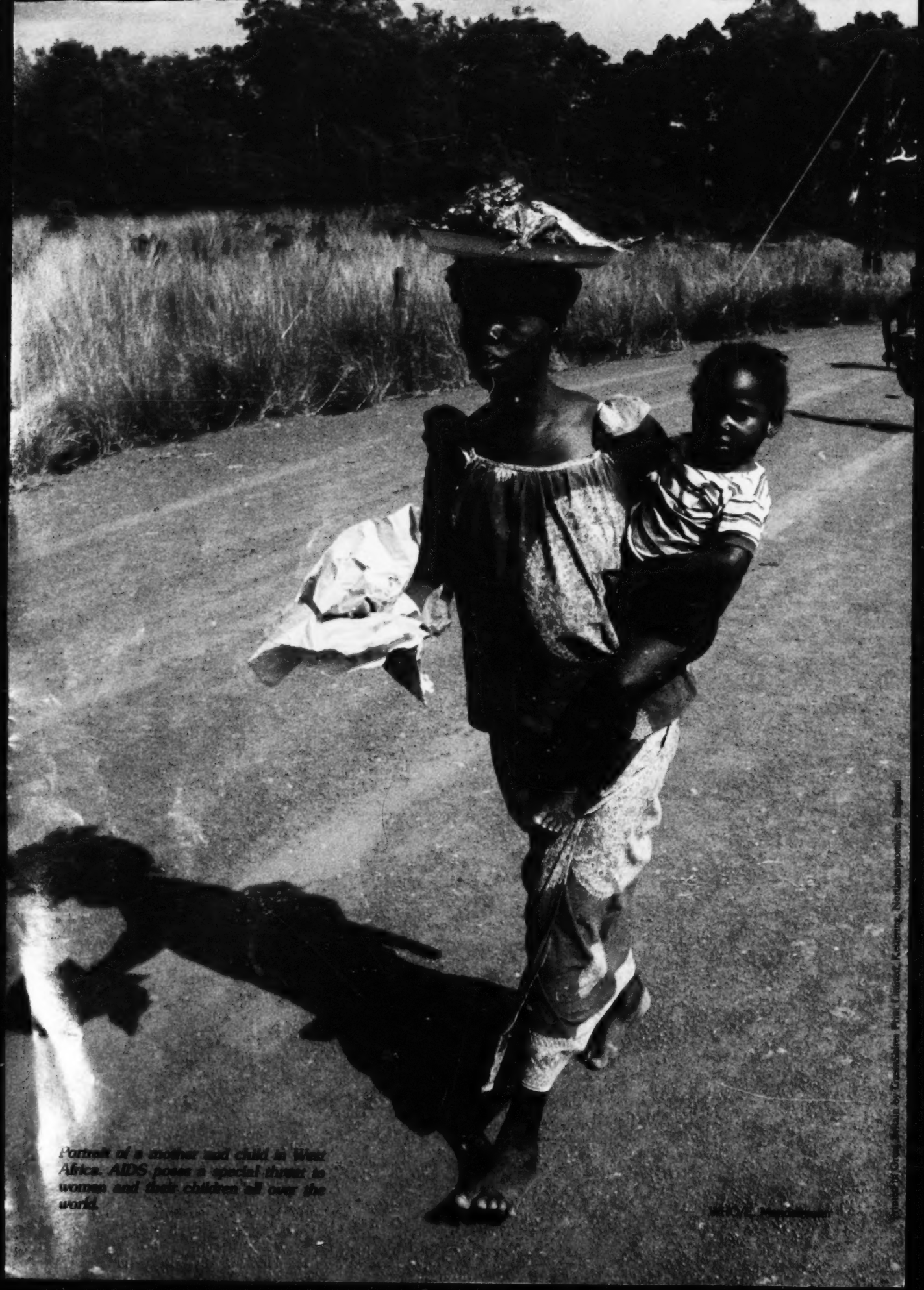

Portrait of a mother and child in West Africa. AIDS poses a special threat to women and their children all over the world.

WHO/L. Manderson

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Courtesy World Health Organization